☐ INITIAL VISIT ☐ FOLLOW-UP VISIT	**MEDICAL RECORD - DIABETES VISIT** For use of this form see MEDCOM Circular 40-8	DATE

SECTION I - PATIENT VITAL SIGNS *(Completed by Health Care Personnel)*

BP: _____ PULSE: _____ RESP: _____ TEMP: _____ HT: _____ WT: _____ BMI: _____

AGE:	Do your use tobacco?	☐ Yes	☐ No	ALLERGY:
RACE:	Want to quit?	☐ Yes	☐ No	
SEX:	Tobacco cessation materials offered?	☐ Yes	☐ No	

SECTION II - PATIENT DEMOGRAPHICS (SUBJECTIVE) *(Filled Out by Patient)*

SINCE YOUR LAST PLANNED DIABETES VISIT HAVE YOU HAD:	YES	NO	REMARKS
1. A diabetes-related ER or hospital visit.			
2. Excessive thirst, hunger, urination or blurred vision or did you have episodes of blood sugar > 180-200?			
3. Shakiness, rapid heart, confusion, night sweats or headache or did you have episodes of blood sugar < 70?			
4. Feet numbness, tingling, burning or cold sensation?			
5. Have you ever had a foot ulcer?			
6. Weight loss or gain of more than 10 pounds in last 6 months?			
7. Change or loss of vision?			
8. Skin problems or rashes?			
9. Female patients - Are you planning a pregnancy now or in the future?			
10. Are you feeling overwhelmed by your diabetes?			

11. When was the date of your last vision exam? _____ Foot Exam? _____
12. How often do you check your blood sugar? _____
13. How often do you check your feet? _____
14. Which food affects your blood glucose the most? ☐ Chicken breast ☐ Salad ☐ Rice or potato ☐ Cheese ☐ Other _____ ☐ Don't know
15. What are your treatment goals for treating your diabetes? My best BP: _____ My best weight: _____
    My best HbA1C: _____ My best blood sugar: _____ My best LDL: _____
16. List all "over the counter" medicines, vitamins, herbals and supplements.

SECTION III - MEDICAL HISTORY, ASSESSMENT, DIAGNOSIS AND TREATMENT (Completed by Health Care Provider)

PART A - PROBLEM LIST (SUBJECTIVE)

ETOH: ☐ Yes ☐ No ☐ Cut down ☐ Annoyed ☐ Guilty ☐ Eye opener

During the past month have you been bothered by feeling: ☐ Down, depressed, or hopeless ☐ Little interest or pleasure in doing things

Home blood glucose monitoring asessed? ☐ Yes ☐ No Medication list reviewed? ☐ Yes ☐ No

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

_____
(Patient's Signature)

SECTION III - MEDICAL HISTORY, ASSESSMENT, DIAGNOSIS AND TREATMENT (Cont)

COMMENTS/ADDITIONAL HISTORY:

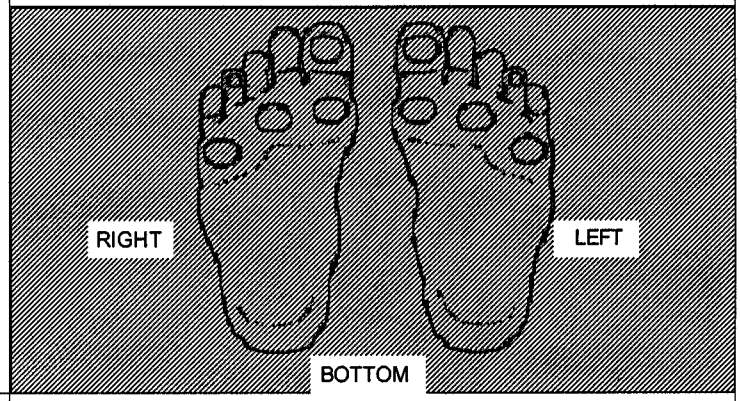
PART B - PHYSICAL EXAM (OBJECTIVE)

PHYSICAL EXAM *(Record significant findings below)*

FOOT EXAM:	☐ NOT ASSESSED	
A. PEDAL PULSES	☐ YES	☐ NO
B. NAILS TOO THICK OR LONG	☐ YES	☐ NO
C. FOOT ABNORMAL SHAPE	☐ YES	☐ NO
D. VIBRATORY SENSE INTACT	☐ YES	☐ NO

DRAW/LABEL FINDINGS

C= Callous, U= Ulcer, M= Maceration, R= Redness, S= Swelling



Lab results in CHCS ☐ YES ☐ NO

MONOFILAMENT EXAM (Draw in circle):
+ = Positive sensation -= Negative sensation

PART C - DIAGNOSIS (ASSESSMENT)

☐ TYPE 1 DM ☐ TYPE 2 DM ☐ ADEQUATE CONTROL - NO CHANGE IN TREATMENT ☐ INADEQUATE CONTROL

WITH:			WITH:		
1. DYSLIPIDEMIA	☐ YES	☐ NO	4. NEUROPATHY	☐ YES	☐ NO
2. HYPERTENSION	☐ YES	☐ NO	5. RETINOPATHY	☐ YES	☐ NO
3. NEPHROPATHY	☐ YES	☐ NO	6. _____	☐ YES	☐ NO

PART D - TREATMENT PLAN (PLAN)

RECOMMEND:

☐ ASA 325 mg ☐ ANNUAL FLU ☐ PNEUMONIA VACCINE ☐ ACE INHIBITOR *(Name&Dose)*: _____

LABS: ☐ HbA1C ☐ LIPIDS ☐ MICRO A/CR RATIO ☐ TSH ☐ CHEM 7 ☐ OTHER: _____

☐ DIABETIC ACTION PLAN REVIEWED AND GIVEN TO PATIENT

PART E - REFERRALS

☐ A. DM PATIENT EDUCATION/ CASE MANAGEMENT	☐ D. NUTRITION THERAPY	☐ H. OTHER
	☐ E. OPHTHALMOLOGY/OPTOMETRY	_____
☐ B. ENDOCRINOLOGY	☐ F. PODIATRY	_____
☐ C. NEPHROLOGY	☐ G. TOBACCO CESSATION PROGRAM	_____

PART F - FOLLOW-UP APPOINTMENT

☐ 1 MONTH ☐ 3 MONTHS ☐ 6 MONTHS ☐ 9 MONTHS ☐ OTHER: _____

_____ _____

(Provider's Name) *(Provider's Signature)*